

Request for List of Disclosures of Protected Health Information



Use this form to request an Accounting of Disclosures of your protected health information (PHI).

Section A: Requesting individual

Please complete the following:

Name:	Phone:	Date of birth:	
Address:			
City:	State:	ZIP code:	Member ID number:

Please read and complete the following:

You have the right to an Accounting of Disclosures that we, or our business associates, have made of your PHI in the six years prior to the date of your request. However, we are not required to account for disclosures that were:

- Made to carry out treatment, payment, or operations.
- Made to the patient or the patient's personal representative.
- Incidental disclosures made in connection with a use or disclosure otherwise permitted or required by the Health Insurance Portability and Accountability Act (HIPAA).
- Made to persons involved in a patient's care or as part of an inpatient directory.
- Pursuant to an authorization for release of information signed by the patient or patient's personal representative.
- Made for national security or intelligence purposes.
- Made to correctional institutions or law enforcement officials under certain circumstances.
- Part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health, or certain health care operations purposes.
- Made prior to April 14, 2003.

Section B: Dates of disclosures

Please specify the date range for the Accounting of Disclosures you are requesting:

Start:	End:
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You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Section C: Signature

I request an Accounting of all Disclosures of my PHI as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for this accounting if I have already received one within the previous 12 months.

Signature:	Date:
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Section D: Personal representative

If you are not the member, please sign and date Section D of this form. Check the box that describes your relationship to the member. **If you are not a parent or legal guardian of the member, please attach proof of your relationship to the member (e.g., power of attorney, personal representative, etc.).**

Print name of personal representative:	
Signature of personal representative:	Date:

- Parent or legal guardian Power of attorney Executor Other

Please return this form to: First Choice Next, Privacy Office, 3875 West Chester Pike, Newtown Square, PA 19073, or email to privacy@amerihealthcaritas.com.